

FIG. 1  
 (PRIOR ART)

PHYSICAL EXAM - Skin Findings

Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/> cyanosis	<input type="button" value="OK"/> <input type="button" value="Cancel"/>
<input type="checkbox"/>	<input type="checkbox"/> cool skin	
<input type="checkbox"/>	<input checked="" type="checkbox"/> skin rash	
<input type="checkbox"/>	<input type="checkbox"/> pallor	
<input type="checkbox"/>	<input type="checkbox"/> diaphoresis	
<input type="checkbox"/>	<input type="checkbox"/> poor skin turgor	

FIG. 2

User

1	2 abc	3 def	
4 ghi	5 jkl	6 mno	
7 prs	8 tuv	9 xyz	
◀	0 qz	C	

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FIG. 3

User rlangdon									
File Edit View Setup									
My Patients									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
7	63y	F	car drove off cliff	Grace	11:26	04/12/01	17 MVA	langdon	
12	18m	M	bean in nose	Ricky	15:44	04/12/01	28 Nose	langdon	

Patients Waiting									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
			NEW COMPLAINT	NEW PATIENT					
	49y	F	horse stepped on foot	Ethyl	16:37	04/12/01			
	118y	F	headache	Mary	16:26	04/12/01			
	56y	M	car crash	Ernie	16:18	04/12/01			
	29y	M	abdominal pain	Jack	15:26	04/12/01			
	37y	M	chest pain	Desi	15:04	04/12/01			

T-Chart	Grace	My Home	Annotations	Notes	Clinical	History	Exam	Course	Dx/Di	Viewing	Report	Discharge	Prescription	Excuse	Printing	Clinical	Discharge	Closure	Print
---------	-------	---------	-------------	-------	----------	---------	------	--------	-------	---------	--------	-----------	--------------	--------	----------	----------	-----------	---------	-------

Title:METHOD FOR ENTERING,  
RECORDING, DISTRIBUTING AND  
REPORTING DATA  
Inventor(s): Woodrow W. Gandy et al  
U.S. Serial # 09/927,972

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[illegible]

User rlangdon									
File		Edit		View		Setup			
My Patients									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
7	63y	F	car drove off cliff	Grace	11:26	04/12/01	17	MVA	langdon
12	18m	M	bean in nose	Ricky	15:44	04/12/01	28	Nose	langdon

Patients Waiting									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
			NEW COMPLAINT	NEW PATIENT					
	49y	F	horse stepped on foot	Ethyl	16:37	04/12/01			
	118y	F	headache	Mary	16:26	04/12/01			
	56y	M	car crash	Ernie	16:18	04/12/01			
	37y	M	chest pain	Desi	15:04	04/12/01			
	29y	M	abdominal pain	Jack	04/12/01	3 2			

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FIG. 5

User rlangdon									
File Edit View Setup									
My Patients									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
7	29y	M	abdominal pain	Jack	15:26 04/12/01		langdon		
12	63y	F	car drove off cliff	Grace	11:26 04/12/01	17 MVA	langdon		
	18m	M	bean in nose	Ricky	15:44 04/12/01	28 Nose	langdon		

Patients Waiting									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
			NEW COMPLAINT	NEW PATIENT					
	49y	F	horse stepped on foot	Ethyl	16:37 04/12/01				
	118y	F	headache	Mary	16:26 04/12/01				
	56y	M	car crash	Ernie	16:18 04/12/01				
	37y	M	chest pain	Desi	15:04 04/12/01				

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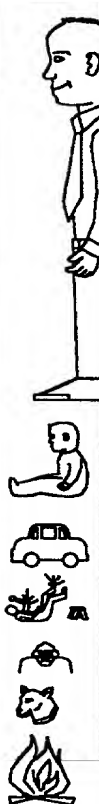
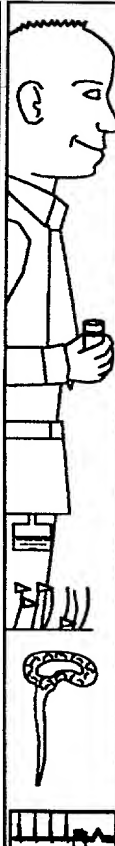
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FIG. 6

User rlangdon															
File Edit View Setup															
My Patients															
Room		Age		Sex		Chief Complaint		Name		Time		Template		Physician	
7		63y		F		car drove off cliff		Grace		11:26 04/12/01		17 MVA		langdon	
8		29y		M		abdominal pain		Jack		15:26 04/12/01				langdon	
12		18m		M		bean in nose		Ricky		15:44 04/12/01		28 Nose		langdon	
Patients Waiting															
Room		Age		Sex		Chief Complaint		Name		Time		Template		Physician	
		49y		F		NEW COMPLAINT horse stepped on foot		NEW PATIENT Ethyl		16:37 04/12/01					
		118y		F		headache		Mary		16:26 04/12/01					
		56y		M		car crash		Ernie		16:18 04/12/01					
		37y		M		chest pain		Desi		15:04 04/12/01					
T-Chart															
Jack															
Home															
Annotations															
Notes															
Clinical															
History															
Exam															
Course															
Dx01															
Viewing															
Report															
Discharge															
Prescription															
Excuse															
Printing															
Clinical															
Discharge															
Closure															
Lock															

FIG. 7

T-Chart Template Selector
✕



	Trauma	Medicine	
	1 Head Injury	26 Headache	
	2 Eye Problems	27 Ear Complaints	
	3 head Injury, Facial	28 Nose	
	4 Neck/Back Pain or Injury	29 Throat or Dental Pain	
	5 Shoulder Injury	30 Cough	
	6 Upper Extremity Injury	31 Wheezing/Asthma	
	7 Trunk Injury	32 Dyspnea	
	8 Low Back Pain or Injury	33 Chest Pain	
	9 Hand/Wrist Injury	34 Palpitations	
	10 Hip Injury	35 Upper Extremity Pain	
	11 Lower Extremity Injury	36 Abdominal Pain	
	12 Ankle/Foot Injury	37 Vomiting/Diarrhea	
	13 Plantar Puncture Wound	38 GI bleeding/Rectal Pain	
	14 Pediatric Illness	39 Female GU	
	15 Asthma-pediatric	40 OB Problems	
	16 Pediatric trauma	41 Male GU	
	17 MVA	42 Lower Extremity Pain	
	17a MCA Bike/Pedestrian	43 Skin Rash/Abscess	
	18 Multiple trauma	44 Allergy	
	19 Fall	45 Changed Mental Status	
	20 Assault	46 Focal Neuro Deficit	
	21 Animal Bite	47 Dizzy	
	22 Major Burn/Smoke Inhalation	48 Syncope	
	23 Recheck/Suture Removal	49 Seizure	
24 General	50 CPR		
	51 Critical Care		
	52 Overdose		
	53 Psych		

Ok
Cancel

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FIG. 8

T-Chart Template Selector

Trauma	Medicine
 1 Head Injury 2 Eye Problems 3 head Injury, Facial 4 Neck/Back Pain or Injury 5 Shoulder Injury 6 Upper Extremity Injury 7 Trunk Injury 8 Low Back Pain or Injury 9 Hand/Wrist Injury 10 Hip Injury 11 Lower Extremity Injury 12 Ankle/Foot Injury 13 Plantar Puncture Wound 14 Pediatric Illness 15 Asthma-pediatric 16 Pediatric trauma 17 MVA 17a MCA Bike/Pedestrian 18 Multiple trauma 19 Fall 20 Assault 21 Animal Bite 22 Major Burn/Smoke Inhalation 23 Recheck/Suture Removal 24 General	 26 Headache 27 Ear Complaints 28 Nose 29 Throat or Dental Pain 30 Cough 31 Wheezing/Asthma 32 Dyspnea 33 Chest Pain 34 Palpitations 35 Upper Extremity Pain 36 Abdominal Pain 37 Vomiting/Diarrhea 38 GI bleeding/Rectal Pain 39 Female GU 40 OB Problems 41 Male GU 42 Lower Extremity Pain 43 Skin Rash/Abscess 44 Allergy 45 Changed Mental Status 46 Focal Neuro Deficit 47 Dizzy 48 Syncope 49 Seizure 50 CPR 51 Critical Care 52 Overdose 53 Psych

Ok Cancel

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FIG. 9A

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		context: _____	
Home		historian: patient EMS family		limited by: _____	
Annotations		OHPI			
L S		chief complaint: abdominal pain _____		flank pain _____	
Notes		started: just PTA today last night yesterday _____			
Clinical		still present _____		gone _____	timing: _____
History		location: R chest, central- L chest			
Exam		epig RUQ upper LUQ L flank			
Course		generalized			
DDI		RLQ LLQ			
Viewing		R flank R pelvis pelvis L pelvis			
Report		suprapub			
Discharge		R back			
Prescription		radiating to: _____		additional pain _____	
Excuse		associated symptoms:			
Printing		nausea _____		vomiting _____	
Clinical		loss of appetite _____		diarrhea _____	
Discharge		severity of pain: _____			
		modifying factors: _____			

GI		vomiting blood _____		CONSTITUTIONAL	
		black stools _____		fever _____	
		bloody stools _____		Neuro & ENT	
URINARY		difficulty w/urination _____		headache _____	
		pain w/urination _____		sore throat _____	
		frequency _____		blurred vision _____	
Female		pregnant _____		CVS & Pulmonary	
LNMP		missed periods _____		chest pain _____	
		abdominal bleeding _____		difficulty breathing _____	
		all systems neg. except as marked		cough _____	
				MS & Skin	
				joint pain _____	
				back pain _____	
				skin rash _____	

OPAST Hx		negative _____		heart diz _____	
		see nurses notes _____		lung diz _____	
		peptic ulcer _____		renal dz _____	
		gall stones _____		HTN _____	
		bowel obstruction _____		diabetes _____	
		kidney stones _____		hyperlipidemia _____	
				previous surgery _____	
				abdominal surgery _____	

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FIG. 9B

<div>Closure</div> <div><div><div></div></div><div><div></div></div></div>		<div><div>A</div><div><div><div>similar symptoms previously: once twice sev. times many times - occasionally frequently milder as bad worse varying</div><div>0</div><div>recently seen ED office clinic hospitalized</div><div>0</div></div></div></div>		<div><div>0 MEDS</div><div>none</div><div>see nurses notes</div></div> <div><div>0 ALLERGIES</div><div>NKDA</div><div>see nurses notes</div></div> <div><div>0 SOCIAL Hx</div><div>smoker</div><div>ETOH</div><div>drugs</div></div> <div><div>residence/travel:</div></div> <div><div>0 FAMILY Hx</div><div>gall bladder</div><div>heart dz</div><div>hx of:</div><div>0</div></div>	
--	--	---	--	---	--

FIG. 10

<div>T-Chart</div>	<div>Abdominal Pain</div> <div>time:</div> <div>room:</div>	<div>OROS</div>
<div>Jack</div>	<div>arrived: pvt vehicle EMS</div> <div>context:</div>	<div>GI</div> <div>vomiting blood</div> <div>black stools</div> <div>bloody stools</div> <div>URINARY</div> <div>difficulty w/urination</div> <div>pain w/urination</div> <div>frequency</div> <div>Female</div> <div>LNMP</div>
<div>Home</div>	<div>historian: patient EMS family limited by:</div> <div>OHPI</div>	<div>CONSTITUTIONAL</div> <div>fever</div> <div>chills</div> <div>Neuro &amp; EENT</div> <div>headache</div> <div>sore throat</div> <div>blurred vision</div> <div>CYS &amp; Pulmonary</div> <div>chest pain</div> <div>difficulty breathing</div> <div>cough</div>
<div>Annotations</div>	<div>chief complaint: abdominal pain</div> <div>flank pain</div> <div>started: just PTA today last night yesterday</div>	
<div>Notes</div>	<div>still present</div> <div>gone</div> <div>timing:</div>	
<div>Clinical</div>	<div>quality</div> <div>"pain"</div> <div>sharp</div> <div>location: R chest</div> <div>central-L chest</div> <div>epig</div>	
<div>History</div>		

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FIG. 11

<b>T-Chart</b>	<b>Abdominal Pain</b>	<b>time:</b> _____ <b>room:</b> _____
<b>Jack</b>	<b>arrived:</b> pvt vehicle EMS _____ <b>context:</b> _____	
<b>Home</b>	<b>historian:</b> patient EMS family _____ <b>limited by:</b> _____	
<b>Annotations</b>	<b>OHPI</b>	
<b>Notes</b>	<b>chief complaint:</b> (abdominal pain) _____ <b>flank pain</b> _____	
<b>Clinical</b>	<b>started:</b> just PTA today <b>last night</b> yesterday _____	
<b>History</b>	<b>still present</b> _____ <b>gone</b> _____ <b>timing:</b> _____	
<b>Exam</b>	<b>quality</b> _____ <b>location:</b> R chest, central-L chest, epig, RUQ upper LUQ, generalized, L flank	
<b>Course</b>	<b>R flank</b> _____ <b>RLQ</b> _____ <b>LLQ</b> _____ <b>R pelvis</b> _____ <b>L pelvis</b> _____ <b>suprapub</b> _____ <b>L back</b> _____	
<b>Viewing</b>	<b>R back</b> _____ <b>L back</b> _____	
<b>Report</b>	<b>radiating to:</b> _____ <b>additional pain</b> _____	
<b>Discharge</b>	<b>associated symptoms:</b> _____ <b>nausea</b> _____ <b>vomiting</b> _____	
<b>Prescription</b>	<b>loss of appetite</b> _____ <b>diarrhea</b> _____	
<b>Excuse</b>	<b>severity of pain:</b> _____	
<b>Printing</b>	<b>modifying factors:</b> _____	
<b>Clinical</b>		
<b>Discharge</b>		

<b>GI</b>	<b>OROS</b>
<b>vomiting blood</b> _____	<b>CONSTITUTIONAL</b>
<b>black stools</b> _____	<b>fever</b> _____ <b>chills</b> _____
<b>bloody stools</b> _____	<b>Neuro &amp; EENT</b>
<b>difficulty w/urination</b> _____	<b>headache</b> _____
<b>pain w/urination</b> _____	<b>sore throat</b> _____
<b>frequency</b> _____	<b>blurred vision</b> _____
<b>Female</b> _____ <b>pregnant</b> _____	<b>CVS &amp; Pulmonary</b>
<b>LNMP</b> _____	<b>chest pain</b> _____
<b>missed periods</b> _____ <b>irreg</b> _____	<b>difficulty breathing</b> _____
<b>abdominal bleeding</b> _____	<b>cough</b> _____
<b>all systems neg. except as marked</b> _____	<b>MS &amp; Skin</b>
	<b>joint pain</b> _____ <b>back pain</b> _____
	<b>skin rash</b> _____
<b>OPAST Hx</b>	
<b>negative</b> _____ <b>see nurses notes</b> _____	<b>heart diz</b> _____ <b>neuro diz</b> _____
<b>peptic ulcer</b> _____	<b>lung diz</b> _____ <b>GI diz</b> _____
<b>gall stones</b> _____	<b>renal dz</b> _____ <b>other dz</b> _____
<b>bowel obstruction</b> _____	<b>HTN</b> _____ <b>diabetes</b> _____
<b>kidney stones</b> _____	<b>hyperlipidemia</b> _____
	<b>previous surgery</b> _____
	<b>abdominal surgery</b> _____

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FIG. 12

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		EMS context: _____	
		historian: patient EMS family		limited by: _____	
OHPI					
Annotations		chief complaint: <u>abdominal pain</u> _____ flank pain _____			
L S		started: just PTA today last night yesterday _____			
Notes		still present _____ gone _____ timing: _____			
Clinical		location: R chest, central-L chest			
History		epig RUQ upper LUQ L flank			
Exam		generalized RUQ LUQ L flank			
Course		R flank R back L back			
DrDI		R pelvis pelvis L pelvis			
Viewing		suprapub ^ additional pain			
Report		radiating to: _____			
Discharge		associated symptoms: _____			
Prescription		nausea _____ vomiting _____			
Excuse		loss of appetite _____ diarrhea _____			
Printing		severity of pain: _____			
Clinical		modifying factors: _____			
Discharge					

OROS		OPAST Hx	
GI	vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ female _____ pregnant _____ LNMP missed periods _____ irreg _____ abdominal bleeding _____ all systems neg. except as marked _____	negative _____ see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____	heart diz _____ neuro diz _____ lung diz _____ GI diz _____ renal dz _____ other dz _____ HTN _____ diabetes _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____
CONSTITUTIONAL			
fever _____ chills _____			
Neuro & EENT			
headache _____			
sore throat _____			
blurred vision _____			
CVS & Pulmonary			
chest pain _____			
difficulty breathing _____			
cough _____			
MS & Skin			
joint pain _____ back pain _____			
skin rash _____			

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FIG. 13

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		context: _____	
		historian: patient EMS family		limited by: _____	
OHPI					
Annotations		chief complaint: <u>abdominal pain</u> _____ flank pain _____			
L S		started: just PTA today last night yesterday _____			
Notes		still present _____ gone _____ timing: _____			
Clinical		location: R chest, central-L chest / epig / RUQ upper LUQ / generalized / L flank			
History		R flank / R back / L back			
Exam		RLQ / LLQ / LQ / R pelvis / L pelvis / suprapub / additional pain			
Course		radiating to: _____ associated symptoms: _____			
Dx/D1		nausea _____ vomiting _____			
Viewing		loss of appetite _____			
Report		severity of pain: _____			
Discharge		modifying factors: _____			
Prescription					
Excuse					
Printing					
Clinical					
Discharge					

OROS	
GI	<u>CONSTITUTIONAL</u> _vomiting blood _____ _black stools _____ _bloody stools _____ <u>URINARY</u> _difficulty w/urination _____ _pain w/urination _____ _frequency _____ Female _pregnant _____ LNMP _____ _missed periods _irreg _____ _abdominal bleeding _____ _all systems neg. except as marked _____
OPAST Hx	_negative _see nurses notes _____ _peptic ulcer _____ _gall stones _____ _bowel obstruction _____ _kidney stones _____ _heart diz _____ _lung diz _____ _renal dz _____ HTN _____ _hyperlipidemia _____ _previous surgery _____ _abdominal surgery _____

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FIG. 14

T-Chart		Abdominal Pain		time: _____	room: _____
Jack	arrived: pvt vehicle EMS	EMS	context: _____		
Home	historian: patient EMS family	limited by: _____			
Annotations	OHPI				
Notes	chief complaint: (abdominal pain) _____ flank pain _____				
	started: just PTA today last night yesterday _____				
	still present _____ gone _____ timing: _____				
Clinical	location: R chest - central - L chest quality: "pain" _____ sharp _____ stabbing _____ cramping _____ burning _____ dull _____ migrating _____ ... well localized _____ diffuse _____				
History	RUQ upper LUQ _____ generalized _____ L flank _____ RLQ _____ ILQ _____ R pelvis _____ L pelvis _____ suprapub _____ R back _____ L back _____				
Exam	radiating to: _____ additional pain _____				
Course	associated symptoms: _____				
Dx/DI	nausea _____ vomiting _____				
Viewing	loss of appetite _____ diarrhea _____				
Report	severity of pain: _____				
Discharge	modifying factors: _____				
Prescription					
Excuse					
Printing					
Clinical					
Discharge					

OROS	
GI	vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ Female _____ pregnant _____ LNMP _____ missed periods _____ irreg _____ abdominal bleeding _____ all systems neg. except as marked _____
CONSTITUTIONAL	fever _____ chills _____ Neuro & EENT headache _____ sore throat _____ blurred vision _____ CVS & Pulmonary chest pain _____ difficulty breathing _____ cough _____ MS & Skin joint pain _____ back pain _____ skin rash _____
OPAST Hx	
negative	see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____
heart diz	lung diz _____ renal dz _____ HTN _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____
neuro diz	GI diz _____ other dz _____ diabetes _____

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FIG. 15

T-Chart	Abdominal Pain	time: _____ room: _____
Jack	arrived: pvt vehicle EMS _____ context: _____	
Home	historian: patient EMS family _____ limited by: _____	
Annotations	OHPH	
Annotations	chief complaint: (abdominal pain) _____ flank pain _____	
Annotations	started: just PTA today last night yesterday _____	
Notes	still present _____ gone _____ timing: _____	
Clinical	location: R chest -central- L chest / epig RUQ upper LUQ generalized R flank RLQ LLQ R pelvis pelvis L pelvis suprapub R back L back	
History	quality "pain" sharp stabbing cramping burning dull migrating ... well localized diffuse	
Exam	radiating to: _____ additional pain _____	
Course	associated symptoms: nausea _____ vomiting _____ loss of appetite _____ diarrhea _____	
Dx/D1	severity of pain: _____	
Viewing	modifying factors: _____	
Report		
Discharge		
Prescription		
Excuse		
Printing		
Clinical		
Discharge		

OROS	GI	CONSTITUTIONAL
	vomiting blood _____	fever _____ chills _____
	black stools _____	Neuro & ENT
	bloody stools _____	headache _____
	URINARY	sore throat _____
	difficulty w/urination _____	blurred vision _____
	pain w/urination _____	CVS & Pulmonary
	frequency _____	chest pain _____
	Female _____ pregnant _____	difficulty breathing _____
	LNMP	cough _____
	missed periods _____ irreg _____	MS & Skin
	abdominal bleeding _____	joint pain _____ back pain _____
	all systems neg. except as marked	skin rash _____
OPAST Hx		
	negative _____ see nurses notes _____	heart diz _____ neuro diz _____
	peptic ulcer _____	lung diz _____ GI diz _____
	gall stones _____	renal dz _____ other dz _____
	bowel obstruction _____	HTN _____ diabetes _____
	kidney stones _____	hyperlipidemia _____
		previous surgery _____
		abdominal surgery _____

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FIG. 16

T-Chart
Jack
Home
Annotations
4 S
Notes
Clinical
History
Exam
Course
Dx/Di
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
A U

### Clinical Report

Hospital Name -

Emergency Department

Street Address - 214-555-1212

12-Apr-2001

Patient Name: Jack

#### HISTORY OF PRESENT ILLNESS

Chief complaint- ABDOMINAL PAIN. He has had nausea and loss of appetite. No vomiting or diarrhea.

Physician Signature

TSYS 25,410

Title:METHOD FOR ENTERING,  
RECORDING, DISTRIBUTING AND  
REPORTING DATA

Inventor(s): Woodrow W. Gandy et al

U.S. Serial # 09/927,972

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FIG. 17

T-Chart	Abdominal Pain	time: _____	room: _____
Jack	arrived: pvt vehicle EMS	EMS context: _____	limited by: _____
GP Home	historian: patient EMS family	OHPI	
Annotations	chief complaint: (abdominal pain)	flank pain	
Annotations	started: just PTA today last night yesterday		
Notes	still present _____	gone _____	timing: _____
Clinical	quality "pain" sharp stabbing cramping burning dull migrating	location: R chest - central - L chest / RUQ upper LUQ generalized	R flank L flank
History		epig RUQ LUQ	
Exam		R pelvis L pelvis	
Course		suprapub	
Dx01			
Viewing	well localized		
Report	diffuse		
Discharge			
Prescription	radiating to: _____	additional pain	
Excuse	associated symptoms:		
Printing	nausea _____	vomiting _____	
Clinical	loss of appetite _____	diarrhea _____	
Discharge	severity of pain: _____		
	modifying factors: _____		

GI	OROS
vomiting blood	CONSTITUTIONAL
black stools	fever chills
bloody stools	Neuro & EENT
difficulty w/urination	headache
pain w/urination	sore throat
frequency	blurred vision
Female pregnant	CVS & Pulmonary
LNMP	chest pain
missed periods irreg	difficulty breathing
abdominal bleeding	cough
all systems neg. except as marked	MS & Skin
	joint pain back pain
	skin rash
OPAST Hx	
negative see nurses notes	heart diz
peptic ulcer	lung diz
gall stones	renal dz
bowel obstruction	HTN diabetes
kidney stones	hyperlipidemia
	previous surgery
	abdominal surgery



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FIG. 18

<b>T-Chart</b>	<b>Abdominal Pain</b> time: _____ room: _____
Jack	arrived: pvt vehicle EMS _____ context: _____
<input checked="" type="checkbox"/> Home	historian: patient EMS family _____ limited by: _____
<b>Annotations</b>	<b>OHPI</b>
<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	chief complaint: (abdominal pain) _____ flank pain _____
<input checked="" type="checkbox"/> Notes	started: just PTA today last night yesterday _____
<b>Clinical</b>	still present _____ gone _____ timing: _____
<input checked="" type="checkbox"/> History	location: R chest - central - L chest _____
<input checked="" type="checkbox"/> Exam	quality: "pain" _____ epig _____ L flank _____
<input checked="" type="checkbox"/> Course	sharp _____ RUQ upper LUQ _____
<input checked="" type="checkbox"/> Dx/Di	stabbing _____ generalized _____
<b>Viewing</b>	cramping _____ R flank _____ L flank _____
<b>Report</b>	burning _____ RUQ _____ LLQ _____
<b>Discharge</b>	dull _____ R pelvis _____ L pelvis _____
<b>Prescription</b>	migrating _____ R back _____ L back _____
<b>Excuse</b>	... well localized _____
<b>Printing</b>	diffuse _____
<b>Clinical</b>	radiating to: _____ additional pain _____
<b>Discharge</b>	associated symptoms: _____
	nausea _____ vomiting _____
	loss of appetite _____ diarrhea _____
	severity of pain: _____
	modifying factors: _____

<b>GI</b>	<b>OROS</b>
<input type="checkbox"/> vomiting blood _____	<b>CONSTITUTIONAL</b>
<input type="checkbox"/> black stools _____	<input type="checkbox"/> fever _____ chills _____
<input type="checkbox"/> bloody stools _____	<input type="checkbox"/> Neuro & EENT _____
<b>URINARY</b>	<input type="checkbox"/> headache _____
<input type="checkbox"/> difficulty w/urination _____	<input type="checkbox"/> sore throat _____
<input type="checkbox"/> pain w/urination _____	<input type="checkbox"/> blurred vision _____
<input type="checkbox"/> frequency _____	<input type="checkbox"/> CVS & Pulmonary _____
<input type="checkbox"/> Female _____ pregnant _____	<input type="checkbox"/> chest pain _____
<b>LNMP</b>	<input type="checkbox"/> difficulty breathing _____
<input type="checkbox"/> missed periods _____	<input type="checkbox"/> cough _____
<input type="checkbox"/> abdominal bleed _____	
<input type="checkbox"/> all systems neg. e _____	

<b>OPAST Hx</b>	<b>minutes</b>	<b>hours</b>	<b>days</b>	<b>weeks</b>	<b>months</b>	<b>years</b>	<b>ago</b>	<b>times</b>
<input type="checkbox"/> negative _____ see nur _____	1 2 3 4 5 -	for 6 7 8 9 0 1/2	several	many	occasionally	today	since yesterday	recently
<input type="checkbox"/> peptic ulcer _____						-gone now	-still present	-improving
<input type="checkbox"/> gall stones _____								chronically
<input type="checkbox"/> bowel obstruction _____								-worsening
<input type="checkbox"/> kidney stones _____								

<b>COUGH</b>	<b>mild</b>	<b>moderate</b>	<b>severe</b>
dry / productive	scant	moderate	copious
clear yellow	green	brown	white
blood tinged	frank	blood	
cough changed from baseline	smoker		
sputum changed from baseline			
... similar to previous symptoms			

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FIG. 19

<b>T-Chart</b>	<b>Abdominal Pain</b> time: room: arrived: pvt vehicle EMS context: historian: patient EMS family limited by: OHPI
<b>Jack</b>	
<b>Home</b>	
<b>Annotations</b>	chief complaint: (abdominal pain) flank pain started: just PTA today last night yesterday
<b>Notes</b>	still present gone timing: location: R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Clinical</b>	quality "pain" sharp stabbing cramping burning dull migrating ... well localized diffuse
<b>History</b>	R flank R back R pelvis pelvis L pelvis suprapub L back
<b>Exam</b>	
<b>Course</b>	
<b>Dx/DI</b>	
<b>Viewing</b>	
<b>Report</b>	
<b>Discharge</b>	
<b>Prescription</b>	
<b>Excuse</b>	
<b>Printing</b>	
<b>Clinical</b>	
<b>Discharge</b>	

<b>OROS</b>	<b>GI</b> vomiting blood black stools bloody stools <b>URINARY</b> difficulty w/urination pain w/urination frequency Female pregnant <b>LNMP</b> missed periods abdominal bleed all systems neg. e	<b>CONSTITUTIONAL</b> fever chills Neuro & EENT headache sore throat blurred vision CVS & Pulmonary chest pain difficulty breathing cough
<b>OPAST Hx</b>	negative see nur peptic ulcer gall stones bowel obstruction kidney stones	<b>COUGH</b> mild moderate severe dry / productive scant moderate copious thick thin clear yellow green brown white blood tinged frank blood cough changed from baseline smoker sputum changed from baseline similar to previous symptoms

minutes hours days weeks months years  
1 2 3 4 5 -  
for 6 7 8 9 0 1/2  
several many occasionally  
today since yesterday recently chronically  
gone now still present improving worsening

208220-24622550

FIG. 20

T-Chart	Jack	Home	Annotations	Notes	Clinical	History	Exam	Course	Dx/DI	Viewing	Report	Discharge	Prescription	Excuse	Printing	Clinical	Discharge	Closure	File
---------	------	------	-------------	-------	----------	---------	------	--------	-------	---------	--------	-----------	--------------	--------	----------	----------	-----------	---------	------

**Clinical Report**  
Hospital Name -  
Emergency Department  
Street Address - 214-555-1212  
12-Apr-2001

Patient Name: Jack

**HISTORY OF PRESENT ILLNESS**  
Chief complaint- ABDOMINAL PAIN. He has had nausea and loss of appetite. No vomiting or diarrhea.

**REVIEW OF SYSTEMS**  
The patient has had a sever cough productive of thick, green, blood tinged sputum. No frankly bloody sputum.

Physician Signature

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FIG. 21

<b>T-Chart</b>		<b>Abdominal Pain</b>		<b>time:</b> _____ <b>room:</b> _____	
Jack		arrived: pvt vehicle EMS		context: _____	
historian: patient EMS family		limited by: _____			
<b>Annotations</b>		<b>OHPI</b>			
chief complaint: <u>abdominal pain</u>		flank pain			
started: just PTA today last night yesterday					
still present _____ gone _____ timing: _____					
location: R chest - central - L chest					
R flank		epig RUQ upper LUQ generalized		L flank	
RLQ LLQ		R pelvis pelvis L pelvis		L back	
suprapub					
R back					
radiating to: _____ additional pain _____					
associated symptoms:		nausea _____ vomiting _____		diarrhea _____	
loss of appetite _____					
severity of pain: _____					
modifying factors: _____					

<b>GI</b>	<b>OROS</b>
<b>vomiting blood</b> _____	<b>CONSTITUTIONAL</b>
<b>black stools</b> _____	<b>fever</b> _____ <b>chills</b> _____
<b>bloody stools</b> _____	<b>Neuro</b> & <b>EENT</b>
<b>URINARY</b>	<b>headache</b> _____
<b>difficulty w/urination</b> _____	<b>sore throat</b> _____
<b>pain w/urination</b> _____	<b>blurred vision</b> _____
<b>frequency</b> _____	<b>CVS &amp; Pulmonary</b>
<b>Female</b> _____ <b>pregnant</b> _____	<b>chest pain</b> _____
<b>LNMP</b> _____	<b>difficulty breathing</b> _____
<b>missed periods</b> _____	<b>(cough)</b> _____
<b>abdominal bleed</b> _____	
<b>all systems neg. e</b> _____	

<b>OPAST Hx</b>	<b>minutes</b> _____	<b>hours</b> _____	<b>days</b> _____	<b>weeks</b> _____	<b>months</b> _____	<b>years</b> _____
<b>negative</b> _____ <b>see nur</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____	<b>5</b> _____	<b>ago</b> _____
<b>peptic ulcer</b> _____	<b>for</b> _____	<b>6</b> _____	<b>7</b> _____	<b>8</b> _____	<b>9</b> _____	<b>times</b> _____
<b>gall stones</b> _____	<b>several</b> _____	<b>many</b> _____	<b>occasionally</b> _____	<b>today</b> _____	<b>since yesterday</b> _____	<b>recently</b> _____
<b>bowel obstruction</b> _____	<b>gone now</b> _____	<b>-still present</b> _____	<b>-improving</b> _____	<b>-worsening</b> _____	<b>chronically</b> _____	<b>-worsening</b> _____
<b>kidney stones</b> _____	<b>COUGH</b>	<b>mild</b> _____	<b>moderate</b> _____	<b>severe</b> _____		
	<b>dry / (productive)</b>	<b>scant</b> _____	<b>moderate</b> _____	<b>copious</b> _____	<b>(thick)</b> _____	<b>thin</b> _____
	<b>clear yellow</b> _____	<b>(green)</b> _____	<b>brown</b> _____	<b>white</b> _____		
	<b>(blood tinged)</b> _____	<b>frank blood</b> _____	<b>cough changed from baseline</b> _____	<b>sputum changed from baseline</b> _____		
	<b>similar to previous symptoms</b> _____					

208220-2622550

FIG. 22

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		EMS context: _____	
Home		historian: patient EMS family		limited by: _____	
Annotations		OHPI			
L S		chief complaint: abdominal pain		flank pain _____	
Notes		started: just PTA today last night yesterday			
Clinical		still present _____ gone _____		timing: _____	
History		location: R chest -central- L chest			
Exam		epig RUQ upper LUQ			
Course		generalized			
DrDI		R flank			
Viewing		L flank			
Report		RLQ LLQ			
Discharge		R pelvis pelvis L pelvis			
Prescription		suprapub			
Excuse		R back			
Printing		L back			
Clinical		radiating to: _____ additional pain _____			
Discharge		associated symptoms: _____			
		nausea _____ vomiting _____			
		loss of appetite _____ diarrhea _____			
		severity of pain: _____			
		modifying factors: _____			

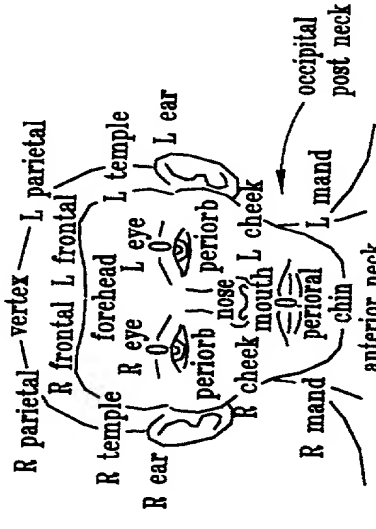
GI		OROS	
vomiting blood _____		CONSTITUTIONAL	
black stools _____		fever _____ chills _____	
bloody stools _____		Neuro & EENT	
URINARY		headache _____	
difficulty w/urination _____		sore throat _____	
pain w/urination _____		blurred vision _____	
frequency _____		CVS & Pulmonary	
Female _____ pregnant _____		chest pain _____	
LNMP		difficulty breathing _____	
missed periods _____ irreg _____		cough _____ severe, productive, thick _____	
abdominal bleeding _____		MS & Skin	
all systems neg. except as marked _____		joint pain _____ back pain _____	
		skin rash _____	
OPAST Hx			
negative _____ see nurses notes _____		heart diz _____ neuro diz _____	
peptic ulcer _____		lung diz _____ GI diz _____	
gall stones _____		renal dz _____ other dz _____	
bowel obstruction _____		HTN _____ diabetes _____	
kidney stones _____		hyperlipidemia _____	
		previous surgery _____	
		abdominal surgery _____	

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FIG. 23

T-Chart		MVA		time: _____ room: _____	
Jim		arrived: pvt vehicle EMS		context: _____	
Home		historian: patient EMS family		limited by: _____	
Annotations		OHPI			
/ S		chief complaint: MVA			
Notes		location of injuries: _____			
Clinical		occurred: just PTA today last night yesterday			
History		pain: none _____ mild _____ moderate _____ severe _____			
Exam		assoc: blow head _____ neck pain _____ LOC _____ dazed _____ seizure _____			
Course		mechanism details: 0			
DrDI		OROS			
Viewing		numbness weakness _____ trouble breathing _____			
Report		hearing loss _____ nausea vomiting _____			
Discharge		loss of vision _____ bladder dysfunction _____			
Prescription		headache _____ skin laceration _____			
Excuse		chest pain _____ fever recently ill _____			
Printing		depressed _____ all systems neg. except as marked _____			
Clinical		OPAST HISTORY			
Discharge		neg see nurses notes heart dz neuro dz			
Closure		tetanus: UTD >5 >10 unk lung dz GI dz			
/		renal dz other dz			
		HTN diabetes			
		previous surgery			
		0 MEDS none see nurses notes			
		0 ALLERGIES NKDA see nurses notes			
		0 SOCIAL HX smoker ETOH drugs			
		residence/travel: _____		0	

bkbdr c-collar _____ nurses notes rev'd _____ VS rev'd _____	
PHYSICAL EXAM	
_alert _____	
_NAD _____	
HEAD	
_Battle's sign _____ raccoon eyes _____	
_non-tender _____	
_no swelling _____	
R parietal—vertex—L parietal	
R frontal L frontal	
forehead L temple	
R temple R eye L eye	
R ear periorb L periorb L ear	
nose periorb L cheek	
R cheek mouth L mand	
R mand periorb chin	
occipital post neck	
anterior neck	
Add'l Injury 0	
NECK	
_verteb. tenderness _____ painful movement _____	
_decrsd ROM _____ muscle spasm _____	
_non-tender _____	
_painless ROM _____	
EYES	
_pupillary exam: _____	
_PERRL _____	
_ocular injury _____	
_abnml fundoscopic _____	
ENT	
_hematympanum _____	
_malocclusion _____	
_no dental injury _____	
_pharynx nml _____	



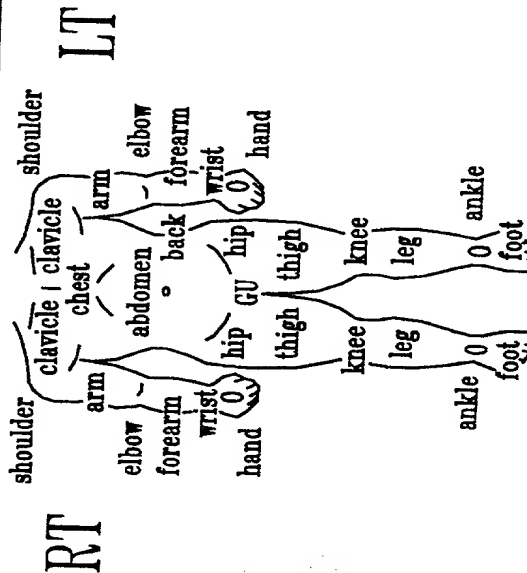


FIG. 25

<b>T-Chart</b>		<b>X-RAYS</b>		<b>o PROCEDURE NOTES</b>	
Jim		_nml / NAD except as noted _____ _independently visualized by me _____ _interpreted by me contemporaneously _____		0 <u>Intubation</u> 0 <u>Ventilator Management</u> 0 <u>Central Line</u> 0 <u>Chest Tube</u> 0 <u>Splint</u> 0 <u>Wound Repair</u>	
Annotations		<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <b>R</b>  </div> <div style="text-align: center;"> <b>L</b>  </div> </div>		<b>PROGRESS</b>  TIME _____ -now- stable unstable sx's much better better unchanged'd exam improved unchanged [APPLY]	
Clinical					
History					
Exam					
Course					
Viewing		0 trauma course    0 Resp / CVS    0 CPR    0 re-evaluation		consultation / review of records _old records ordered _____ _old records reviewed _____ _records req - unavailable _____ _further history sought _____	
Report		D/W Dr. _____ D/W Dr. (#2) _____ _tried - can't contact Dr. _____ _family consultation _____		hospital admission or transfer _admitted _____ _transferred _____ _observation status _____	
Discharge		0 EKG _nml    0 CT Head _NAD    0 CT Abdomen _NAD 0 Labs _nml    0 CT Chest _NAD    0 Other studies _neg			



FIG. 26

[illegible]

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26/36

FIG. 27

<b>T-Chart</b>		<b>Abdominal Pain</b> time: _____ room: _____	
Mary		arrived: pvt vehicle EMS context: _____	
<input checked="" type="checkbox"/> Home		historian: patient EMS family limited	
<b>Annotations</b>		<b>OHPI</b>	
/ 8		chief complaint: abdominal pain _____ flank pa	
		started: just PTA today last night yesterday	
<b>Notes</b>		still present _____ gone _____ timing: _____	
<b>Clinical</b>		quality: _____ location: R chest-central-L chest	
<input checked="" type="checkbox"/> History		"pain" sharp RUQ upper LUQ	
<b>Exam</b>		stabbing epig	
<b>Course</b>		cramping generalized	
<b>Dx/DI</b>		burning R flank	
<b>Viewing</b>		dull RUQ LUQ	
<b>Report</b>		migrating R pelvis L pelvis	
<b>Discharge</b>		... well localized R back	
<b>Prescription</b>		diffuse R back	
<b>Excuse</b>		radiating to: _____ additional pain	
<b>Printing</b>		associated symptoms: _____	
<b>Clinical</b>		nausea _____ vomiting	
<b>Discharge</b>		loss of appetite _____ diarrhea	
		severity of pain: _____	
		modifying factors: _____	

other	
<b>CONST</b> fever _____ chills _____ mus aches _____ weight loss _____	<b>OTHER HISTORY</b> <b>CVS-PESP</b> chest pain _____ palps _____ dyspnea _____ cough _____ foot swing _____ calf pain _____ <b>GI</b> nausea _____ vomiting _____
<b>EYES</b> irrit eyes _____ der vision _____ photophob _____ dble visn _____	<b>MUSCULOSKEL</b> neck pain _____ back pain _____ joint pain _____ <b>SKIN</b> skin rash _____ skin lesion _____ insect bite _____ skin lac _____
<b>EAR</b> ear pain _____ ear draining _____ tinnitus _____ hrng loss _____	<b>NEURO/PSYCH</b>
<b>NOSE</b> congestion _____ runny nose _____ nosebleed _____ sinus pain _____	
<b>THROAT</b> sore thrt _____	

<b>VOMITING</b> mild moderate severe once twice several times numerous blood-tinged w/frank blood dark coffee-grounds billous faculent ... similar to previous symptoms	
---	--

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FIG. 28A

nurses notes rev'd		VS rev'd		0 2/other	
PHYSICAL EXAM					
alert					
NAD					
anxious / lethargic / obtunded					
in distress mild mod severe					
conjunctival findings					
scleral icterus					
pale conjunctivae					
abnml ear exam					
runny nose					
pharyngeal erythema					
tonsillar exudate					
dry mucous membranes					
JVD					
cardoid bruit					
lymphadenopathy					
thyromegaly					
meningeal signs					
abnml rate tachycardia bradycardia					
abnml rhythm					
murmur					
extra sounds					
decrsd pulses					
resp distress					
accessory muscles					
decreased air movement					
rales					
RESPIRATORY					
no resp distress					
breath sounds nml					
chest nontender					
CVS					
nml rate/rhythm					
heart sounds nml					
ENT					
ears nml					
nose nml					
pharynx nml					
NECK					
nml inspection					
supple					
CVS					
nml rate/rhythm					
heart sounds nml					
RESPIRATORY					
no resp distress					
breath sounds nml					
chest nontender					
ABDOMEN					
soft					
nontender					
no organomegaly					
obese					
tenderness #1					
scar					
other #2					
guarding					
rebound					
organomegaly					
gravid uterus					
abnml bowel sounds					
distention					
mass					
vag. bleeding					
discharge					
bimanual tenderness					
enlarged uterus					
mass					
tenderness					
scrotal swelling					
blood in stool					
tenderness					
abnormal digital rectal					
CVA tenderness					
pedal edema					
calf tenderness					
cyanosis					
cool skin					
pallor					
diaphoresis					
SKIN					
nml color					
RECTAL					
nml rectal exam					
nontender					
hemo neg stool					
BACK					
nml inspection					
EXTREMITIES					
nml ROM					
no pedal edema					
MALE GENITALIA					
nml genitalia					
testes descended					
0 FEM GENITALIA					
external exam nml					
bimanual exam nml					
speculum exam nml					
tenderness					
scrotal swelling					
blood in stool					
tenderness					
abnormal digital rectal					
CVA tenderness					
pedal edema					
calf tenderness					
cyanosis					
cool skin					
pallor					
diaphoresis					
SKIN					
nml color					

TSYS 25,410  
Title:METHOD FOR ENTERING,  
RECORDING, DISTRIBUTING AND  
REPORTING DATA  
Inventor(s): Woodrow W. Gandy et al  
U.S. Serial # 09/927,972

27/36

28/36

**FIG. 28B**

FIG. 28B

rhonchi  

  wheezes  

  prolonged expirations

warm, dry  

  no rash  

  0 NEURO  

  oriented x  

  no motor deficit  

  no sensory deficit  

  reflexes nml

skin rash  

  altered mental status  

  CN deficit  

  weakness  

  sensory deficit  

  reflex exam:

poor skin turgor

FIG. 29

**Clinical Report**  
Hospital Name - Emergency Department  
Street Address - 214-555-1212  
12-Apr-2001

---

Patient Name: Mary

**PHYSICAL EXAM**  
Eyes: Scleral icterus. Pale conjunctivae.  
ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.  
Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.  
Abdomen: Obese. Rebound tenderness. Guarding present.  
Skin: Cyanosis. Skin rash.  
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

---

Physician Signature

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FIG. 30

EVI		nurses notes rev'd		VS rev'd		0 2/other		ABDOMEN		obese		scar		other	
Jane		PHYSICAL EXAM		gyn		soft		tenderness		#1		#2		#2	
Alert		_anx		_in d		_conj		_scl		_pale		_abn		_run	
NAD		_nml inspection		_ph		_tons		_dry		_JVD		_cart		_lym	
EYES		_PERRL		_pharynx nml		_nose nml		_ears nml		_nml inspection		_supple		_men	
ENT		_pharynx nml		_nose nml		_ears nml		_nml inspection		_supple		_men		_abn	
NECK		_nml inspection		_supple		_men		_abn		_nml rate/rhythm		_heart sounds nml		_dec	
CVS		_nml rate/rhythm		_heart sounds nml		_dec		_resp		_acce		_decr		_rale	
RESPIRATORY		_no resp distress		_breath sounds nml		_chest nontender		_nml rectal exam		_heme neg stool		_nontender			
RECTAL		_nml rectal exam		_heme neg stool		_nontender									
EXTERNAL EXAM		_external exam nml		_speculum exam nml		_no vag discharge		_no cervical lesions		_os closed					
SPECULUM		_herpes-like lesion(s)		_vaginal discharge		_vag. bleeding		_IUD string visible		_cervical erosion		_cervicitis		_cervical lesion	
BIMANUAL		_cervical discharge		_cervical dilation		_cervical os open		_tissue in os in vagina		_cervical effacement		_cerv. motion tenderness		_bimanual tenderness	
RECTOVAG		_pelvic mass		_adnexal tenderness		_adnexal mass / fullness		_retroverted uterus		_retroflexed uterus		_uterine tenderness		_enlarged uterus	
DECREASED RECTAL TONE		_blood in stool		_abnormal digital rectal											
PALLOR		_diaphoresis													

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FIG. 31

T-Chart
Jane
Home
Annotations
4 8
Notes
Clinical
History
Exam
Course
Dx/DI
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
1 1

## Clinical Report

Hospital Name-

Emergency Department

Street Address - 214-555-1212

26-Jul-2001

Patient Name: Jane

### PAST HISTORY

Peptic ulcer, Gall stones, Bowel obstruction

### PHYSICAL EXAM

Eyes: Scleral icterus. Pale conjunctivae.

ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.

Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.

Abdomen: Obese. Rebound tenderness. Guarding present.

GU: Speculum and bimanual exam performed. Cervical lesion present.

Discharge present from the cervical os.

Skin: Cyanosis. Skin rash.

Neuro: Oriented X 3. No motor deficit. No sensory deficit.

Physician Signature

FIG. 32

[illegible]

FIG. 33

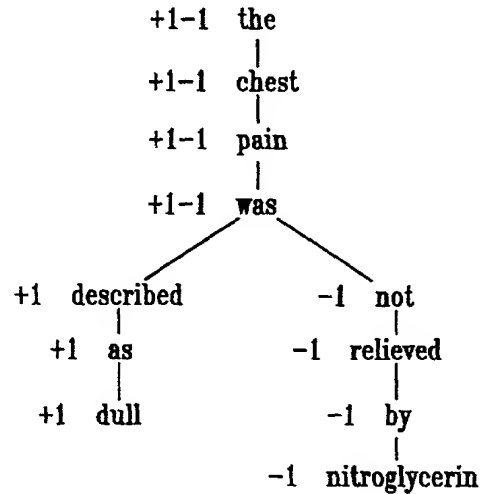
T-Chart		EKG / X-RAYS / STUDIES		PROCEDURE NOTES	
Jane		<input type="checkbox"/> EKG _nml <input type="checkbox"/> CXR _NAD <input type="checkbox"/> V/q scan _nml <input type="checkbox"/> Abdomen _NAD <input type="checkbox"/> IVP _NAD <input type="checkbox"/> Other X-rays _neg		<input type="checkbox"/> CT Head _NAD <input type="checkbox"/> CT Chest _NAD <input type="checkbox"/> CT Abdomen _NAD <input type="checkbox"/> Abdominal Sono _NAD <input type="checkbox"/> Pelvic Sono _NAD <input type="checkbox"/> Other studies _neg	
<input type="checkbox"/> Home <input type="checkbox"/> Annotations <input type="checkbox"/> Notes		LAB		PROGRESS TIME: ___ - now stable unstable sx's gone much better better unchanged exam improved unchanged	
<input type="checkbox"/> Clinical <input type="checkbox"/> History <input type="checkbox"/> Exam <input type="checkbox"/> Course <input type="checkbox"/> Dx/Di <input type="checkbox"/> Viewing <input type="checkbox"/> Report <input type="checkbox"/> Discharge <input type="checkbox"/> Prescription <input type="checkbox"/> Excuse <input type="checkbox"/> Printing <input type="checkbox"/> Clinical <input type="checkbox"/> Discharge		<input type="checkbox"/> CBC nml except WBC Hgb HCT Plat segs bands lymphs monos <input type="checkbox"/> COAG PT PTT INR TYPE / Rh Time T & C Type/Rh		<input type="checkbox"/> Cardiac Enz nml except CK CKMB myoglobin Troponin T Troponin I <input type="checkbox"/> Pulse Ox time FI02 O2 sat <input type="checkbox"/> ABG time FI02 pO2 O2 sat pCO2 pH	
		<input type="checkbox"/> Chem CMP BMP ISTAT nml except Na K Cl HCO3 Glu #2 BUN Cr Tol Prol Albumin T.Bili SGOT Alk Phos Ca Mg PO4 Amylase Lipase		<input type="checkbox"/> PFTs Peak Flow <input type="checkbox"/> U/A cath clean nml except WBCs RBCs bacteria blood leuk est nitrite gluc ketones Bili protein HCG sHCG Quant uHCG	
				Evaluation after reassessment. Physical exam findings are unchanged. [APPLY] Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged. Evaluation after observation, results of tests back, analgesic and narcotic. Physical exam findings are improved. Symptoms much better. <input type="checkbox"/> general course <input type="checkbox"/> Resp / CVS <input type="checkbox"/> CPR <input type="checkbox"/> re-evaluation consultation / review of records D/W Dr. ___ old records ordered ___ D/W Dr. (#2) ___ old records reviewed ___ tried - can't contact Dr. ___ records req-unavailable ___ family consultation ___ further history sought ___ hospital admission or transfer admit ___ good condition ___ transfer ___ stable ___ observation status ___	



FIG. 34

T-Chart	Clinical Report	
Jane	Hospital Name--	
Home	Emergency Department	
Annotations	Street Address - 214-555-1212	
Annotations	26-Jul-2001	
Notes	Patient Name: Jane	
Clinical	PAST HISTORY	
Clinical History	Peptic ulcer, Gall stones, Bowel obstruction	
Exam	PHYSICAL EXAM	
Course	Eyes: Scleral icterus. Pale conjunctivae.	
DDI	ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.	
Viewing	Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.	
Report	Abdomen: Obese. Rebound tenderness. Guarding present.	
Discharge	GU: Speculum and bimanual exam performed. Cervical lesion present. Discharge present from the cervical os.	
Prescription	Skin: Cyanosis. Skin rash.	
Excuse	Neuro: Oriented X 3. No motor deficit. No sensory deficit.	
Printing	PROGRESS AND PROCEDURES	
Clinical	E.D. Course: Evaluation after reassessment. Physical exam findings unchanged.	
Discharge	Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged.	
Closure	Evaluation after observation, results of tests back, analgesis and narcotic. Physical exam findings are improved. Symptoms much better.	
Closure	Physician Signature	

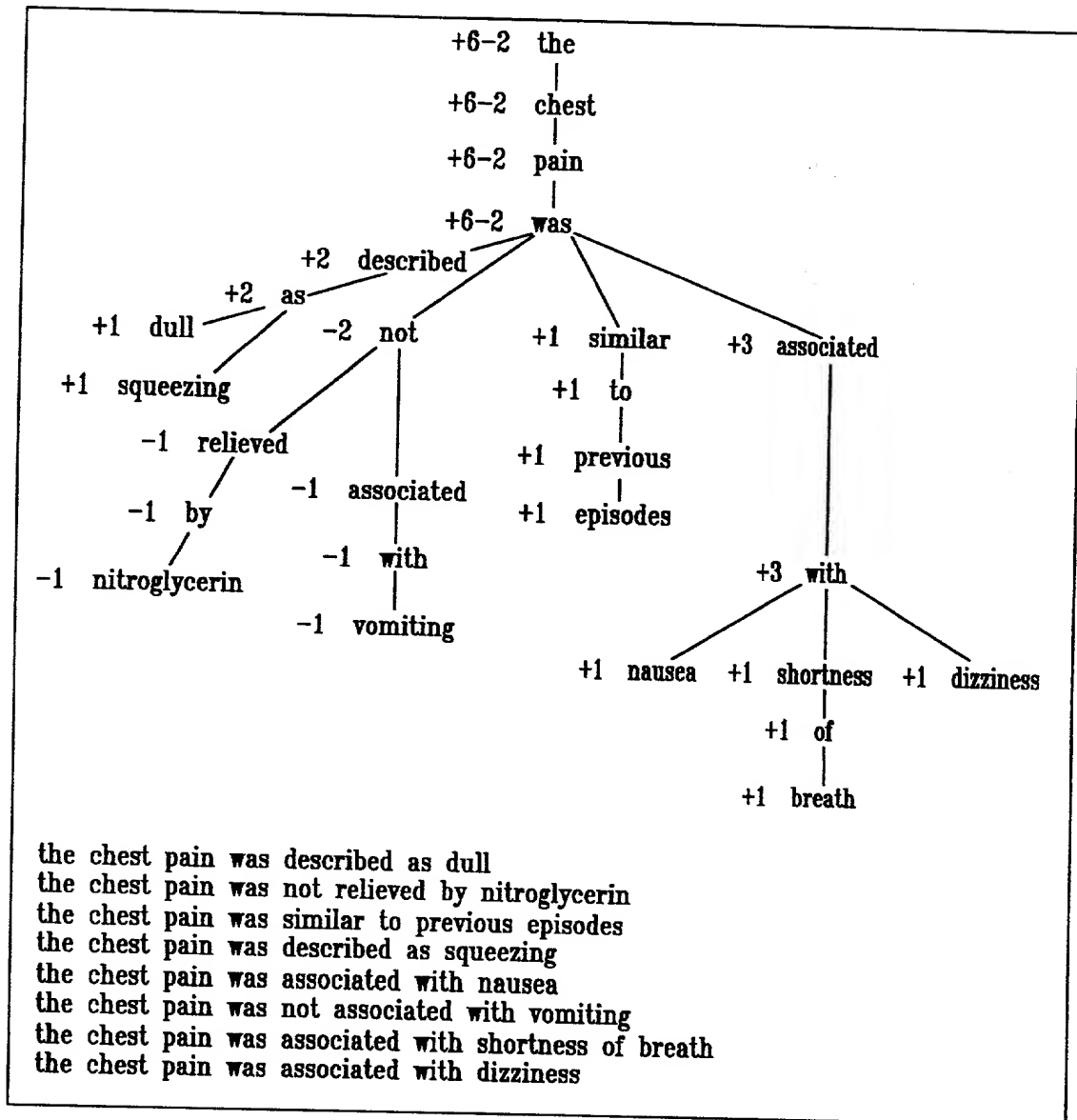
FIG. 35



the chest pain was described as dull  
the chest pain was not relieved by nitroglycerin

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FIG. 36



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FIG. 37

Test TSysTPRL

the patient has had a prior history of \*\* cancer of the stomach

the patient has had a prior history of \*\* cancer of the brain

the patient has had a prior history of \*\* diabetes

the patient has had a prior history of \*\* congestive heart failure

the patient has had a prior history of \*\* gout

the patient has had a prior history of \*\* ingrown toenails

the patient has had a prior history of \*\* alcohol abuse

the patient has had a prior history of \*\* scabies

Generate

Min Text

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Semicolon

Comma

Crunch

The patient has had a prior history of cancer of the stomach, cancer of the brain, diabetes, congestive heart failure, gout, ingrown toenails, alcohol abuse and scabies.